Provider Perspectives on Disaster Mental Health Services in Oklahoma City

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SUMMARY. Seven years after the bombing of the Murrah Federal Building in Oklahoma City, 34 individuals affiliated with various organizations were interviewed about their experiences in providing disaster mental health services to victims and the community. Their perspectives elucidated the importance of preparedness, training and education, local control, interagency cooperation, and psychosocial support for providers. Significant conflicts emerged among providers about credentials,

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referrals, the quality of services provided, and the appropriateness, in this context, of basing services solely on a crisis counseling model. The lack of ongoing needs assessment or evaluation data further fueled the debates. On the basis of the findings, the authors outline several recommendations for planning mental health responses to future terrorist attacks.

KEYWORDS. Disaster, terrorism, mental health services, Oklahoma City bombing

On April 19, 1995, a truck bomb exploded in front of the Murrah Federal Building in Oklahoma City, Oklahoma (OKC), killing 168 people, including 19 children, and injuring another 500. The bombing generated immense concern among mental health professionals about how to meet the needs of direct victims, surviving family members, and the community as a whole. The primary response was Project Heartland, a crisis counseling program implemented by Oklahoma's Department of Mental Health and Substance Abuse Services (DMHSAS). Most of the funding for Project Heartland was provided by the Federal Emergency Management Agency (FEMA), as administered by the Center for Mental Health Services (CMHS). The Office of Victims of Crime, Red Cross, and various charities and grants also provided funding for mental health services.

Seven years after the bombing, our evaluation team visited OKC to document the perspectives of local people who had played important roles in developing, implementing, or providing disaster mental health services (DMHS). Our goal was to learn lessons from OKC's experience that could be useful to other communities that must respond to major disasters.

A systems perspective on service delivery (Figure 1) guided the study. DMHS systems are imposed upon host systems that have pre-existing missions. They are both assisted and constrained by the federal system of emergency management. Characteristics such as credibility and accessibility are criteria for evaluation of service delivery (Hodgkinson & Stewart, 1998). Forming the essential link between the DMHS system and the consumer, providers are influenced by (a) host system characteristics, especially preparedness; (b) fit between their own orientations and DMHS principles (Allen, 1993; Flynn, 1994; Jacobs & Kulkarni, 1999; Myers, 1994; Pfefferbaum,

North, Flynn, Norris, & DeMartino, 2002; Young, Ruzek, & Gusman, 1999); and (c) service coordination. Turf boundaries, poor interagency linkages, communication gaps, confusion, and ambivalence regarding outsiders have been identified as issues that interfere with service delivery and add to the stressfulness of disaster work (American Psychological Association [APA], 1997; Bowenkamp, 2000; Call & Pfefferbaum, 1999; Canterbury & Yule, 1999; Gillespie & Murty, 1994; Hodgkinson & Stewart, 1998; Lanou, 1993; Sitterle & Gurwich, 1998). A "culture of chaos" is endemic to disaster work, but coordinated networks provide workers with information, knowledge, and opportunities to support each other (Campbell & Ahrens, 1998). In summary, we began our work with the assumption that providers who function within *coherent and supportive* DMHS systems will deliver services that are perceived to be credible, acceptable, accessible, and proactive, thereby maximizing the reach of the program to those in need.

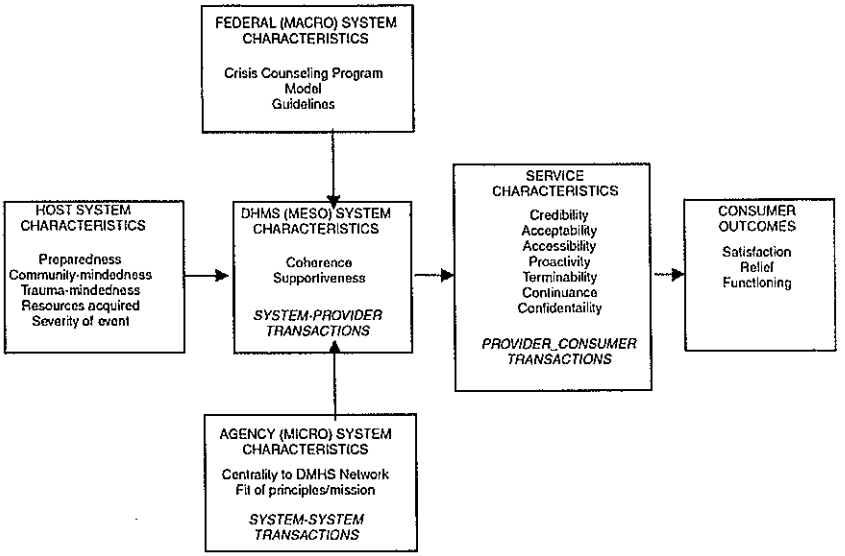
METHODS

In April 2002, four psychologists, working in pairs, interviewed 34 individuals affiliated with various organizations that provided a range of services after the bombing. Project Heartland (PH) was the federally funded crisis counseling program implemented by DMHSAS. Catholic Charities, Consumer Council, Community Counseling Center, and Latino Community Development Agency were PH subcontractors. The OKC Community Foundation administered funds received as charitable donations. First Christian Church was the site of the Compassion Center operated by the Red Cross in collaboration with the Oklahoma Psychological Association Disaster Response Network. The University of Oklahoma Health Sciences Center, Fire Department, Police Department, and VA Medical Center also played significant roles in the response.

None of the interviewers were from OKC or had provided services after the bombing. (Betty Pfefferbaum, one of the authors and planners of the study, did not conduct interviews or have access to the data.) The interview guide included broad questions about participants' roles, activities, training, interactions, stress management, service characteristics, and barriers. Interviews were audiotaped and transcribed.

Data were analyzed to identify key findings within six action-themes: (a) preparing for disaster, (b) training the workers, (c) negotiating insider-outsider dynamics, (d) implementing an interagency response, (e) caring for the workers, and (f) serving the consumer. *Data* refer to the verbatim transcriptions, *findings* to consensually agreed-upon paraphrases or summaries of the data, and *conclusions* to investigator interpretations of the findings.

FIGURE 1. Conceptual Framework: A Systems Perspective on Service Delivery



FINDINGS

Preparing for Disaster

Participants valued preparedness highly, often commenting on how their own preparedness or lack thereof influenced their ability to respond quickly, competently, and appropriately. Most participants did not perceive OKC to have been well prepared. Several findings emerged within this theme. First, participants noted that providers need to be prepared for their own anxiety and must understand how their own experiences will influence their ability to cope with their roles. Attention to providers' stress and health is crucial and should be part of the overall preparedness plan. Second, respondents emphasized the need to know how to create and manage an emergency mental health response. Developing networks, coalitions, and cooperative agreements ahead of time was seen as very important. The plan should indicate how key constituencies will be involved and how volunteers will be managed. Respondents also believed that advanced designation of responsibilities and chains of command would reduce confusion and conflict.

Participants identified many barriers to preparedness. Mental health professionals are often not interested in disaster response until a significant event oc-

curs in their community. Necessary coalitions and networks may not exist ahead of time. Funding for training and planning is limited. Organizations that have played lead roles in one disaster may not want to take on this burden again.

Some data contradicted our finding that preparedness was viewed as critical. At the time of the interviews, the State still did not have a formal, written plan for conducting a disaster mental health response, expecting instead to draw on the rich experience gained in the aftermath of the bombing.

Training the Workers

Disaster mental health training (Red Cross and/or Critical Incident Stress Debriefing) was seen as very valuable. It was valued not only for the information it provided but also because of the access and credibility it afforded. Several nationally recognized experts came to OKC and provided training in specific topics such as PTSD and traumatic grief. With a few exceptions, comments about these trainings were positive. One participant noted that training served as a form of stress management by allowing her to take a break from direct service provision while thinking about the issues with more distance.

Limitations of training were also noted. Several participants were adamant that disaster mental health training alone was not adequate to prepare someone to work directly with trauma survivors and could not substitute for a professional education. Often, comments about the limitations of training co-occurred with strong criticisms of using paraprofessionals (e.g., persons with a Bachelor's degree or less) in disaster response.

According to participants, training should cover: (a) the range of mental health responses to trauma, including PTSD, acute stress, depression, suicidality, grief, and anger; (b) influences of pre-existing experiences and conditions; (c) family/marital issues; (d) psychological treatments; (e) workings/mandates of authorities; (f) skills for dealing with/using media; and (g) vicarious trauma and stress management. Participants recommended that trainings emphasize practical rather than theoretical issues. Case examples, mock scenarios, and drills were preferred modes. Trainings should be sensitive to perspectives of diverse cultures.

Negotiating Insider-Outsider Dynamics

Local professionals appeared to feel a strong sense of "ownership" of the disaster. Outsiders who implied that the local community was not capable of managing the situation were strongly resented. Because she asked the mayor what OKC was going to do until the "experts" arrived, newswoman Connie

Chung became a symbol of an arrogant outsider. She was mentioned in numerous interviews. Outsiders must be highly respectful of local people.

Unsolicited offers of help from self-identified experts were generally not received well. Having to deal with the volume of offers to help, letters, and donations placed a burden on gatekeepers in the community. However, individuals and organizations that were invited in because of their experience or expertise were seen as enormously helpful. The help was most appreciated when it played a supporting role to local leadership. Being invited to assist versus simply showing up was thus the most critical factor.

Implementing an Interagency Mental Health Response

The American Red Cross, First Christian Church, and local psychologists and clergy created a safe, protective environment for families of the bombing victims that came to be known as the Compassion Center. Local psychologists who played leadership roles at the Center were adamant about the necessity for minimal qualifications of those who worked with the families (masters degree) or served on death notification teams (doctorate degree). This structure did cause some conflicts. PH leaders who did not have Red Cross credentials were denied access to the Center and were very unhappy about this. Conversely, Compassion Center workers were "horrified" that PH staff had no prior training in disaster mental health.

Transitions from national to local leadership and from Red Cross to PH were not always accomplished smoothly. The sentiment was that local providers were able to coordinate and provide services more effectively once the national agencies left OKC. The Red Cross would not share its list of service recipients with state authorities, making it more difficult for the state to conduct its needs assessment. It was noted that other states have had the same problem. Implementation and management of PH posed numerous challenges. It was not initially clear who would serve as the lead agency for the FEMA-funded crisis counseling program. DMHSAS leadership struggled to keep up with meetings scheduled around OKC and plans made by various groups. A critical point was when the Governor's Office designated DMHSAS as the lead agency for the mental health response.

Both PH leadership and the subcontractors supported the idea, novel at the time, of using subcontractors to reach different segments of the population. The coordination of subcontractors was challenging at times. It was important to provide them oversight and technical assistance in creating materials for education and outreach. One subcontractor did not comply with the requirements of the subcontract, resulting in termination of the relationship. The subcontractors had a good sense of camaraderie, met often, and felt that management

was highly supportive of their efforts. They believed they understood their specific responsibilities within the larger mission.

There were many examples of interagency cooperation. Participants who helped victims financially believed that PH had good relationships with other community-based agencies and that it was easy to make referrals to PH. The resource coordinating committee, which met on a regular basis to address the unmet needs of victims, aimed to provide "one-stop shopping" for the client and was well received.

However, considerable conflict emerged between PH and local psychologists and psychiatrists who often felt that PH staff were not equipped to deal with more severe problems and could not provide needed medication. Policies prohibiting record-keeping interfered with collaboration with medical professionals because of the latter's concerns about liability. Some participants believed that PH was closed to influence from professionals outside of the PH system. Some felt strongly that PH failed to refer their clients to other professionals as often as needed. This generally went hand in hand with the view that PH therapists were not particularly accomplished and "refused to let go of people" because of their own issues. PH staff believed they did make referrals when warranted and that more professionals should have been willing to offer their services for reduced fees. The sentiment was expressed, and told with salient examples, that private practitioners were "greedy" and "just after the money." Work styles (e.g., willingness to work within the school rather than in one's office) were identified as an additional barrier to working with private practitioners. According to PH, referral of rescue workers was particularly problematic; reluctance on the part of some rescue workers to have their care transferred to other providers after establishing a trusting relationship at PH complicated their treatment.

Caring for the Worker

Stories were relayed of providers who took years to recover and suffered serious consequences to their health (see also Wee & Myers, 2002). Stress and stress management were quite salient, and required that we spend more time discussing these issues with the participants than we had originally planned.

Features of disaster mental health work that make it extraordinarily stressful include its urgency and risk for emotional involvement with victims. "Self-imposed pressure" or an "internal need to hurry, hurry, hurry" led providers to put in long hours for an extended period. It was difficult for them to focus on and address their own needs. Normal activities were set aside or forgotten, creating problems at home that exacerbated the stressfulness of the work. Some participants noted the danger of getting too involved emotionally with vic-

tims. "If we can't separate ourselves from that, then we are going to be affected by it." As one participant noted, "It's hard to keep that distance, that professional distance, when you're seeing such intense pain. It was impossible for me." The extent of provider stress was not recognized until well after the event. Upper-level management said that they did not receive feedback until many of the problems were serious.

That stress can have consequences for the well-being of entire organizations, as well as individuals, was neither anticipated nor addressed by PH or other mental health programs. This fact was especially evident at the church that provided space for the Compassion Center. Church leaders became increasingly disenfranchised as the "bureaucracy" at the Center increased and their role diminished. They were scolded for inviting families to services, which seemed only hospitable to them, and criticized for using donations to repair the damage that had been done to the building by the thousands of adults, children, workers, journalists, and even animals that occupied it for weeks. Predictably, conflicts within the congregation emerged about what to do with the unsolicited financial donations the church received. As one lay leader summarized their experience, "No building can house that much pain without being affected by it."

Solutions often emphasized imposed, systemic constraints. Some participants believed it would be advisable to limit the hours worked per day (e.g., 6 hours) or the total amount of time devoted to this work (e.g., rotating off after one year). Adequate numbers of staff at all levels (administrative, counselors, support staff, media relations) must be hired to reduce the pressure on individuals. Weekly case supervision is essential, and individual therapy for workers should be made available as well.

Participants also provided advice about self-care, including being aware of one's own limits, knowing what jobs are a good match, and retaining social/recreational activities. Writing, whether academic or personal, was helpful for many, as were activities that foster relaxation, such as massage and deep breathing. Providers should avoid over-exposure to media coverage of the disaster.

Serving the Consumer

Participants were shown definitions of seven characteristics proposed to be important for DMHS (Hodgkinson & Stewart, 1998). With the exception of *terminability* (meaning that the service is seen as having an endpoint), participants agreed that the proposed characteristics served as valuable goals for service delivery in disaster-stricken settings. PH received high marks with regard to *accessibility* (service is provided in the heart of the affected community),

acceptability (help does not demean the recipient), *confidentiality* (survivors believe that their privacy is assured), and *proactivity* (service reaches out to those most affected). *Credibility* (service is seen by survivors as offering something that will be of use) received the most discussion of the seven characteristics. Many participants disagreed with the definition provided, placing more emphasis on credentials and training as the central components of credibility. They also noted being trustworthy and knowing what one was doing, as reflected in the statement, "She gets us, she knows cops." *Continuance* (that the service must be present for a sufficient period to meet the need) was believed by many to have not been achieved because of the emphasis on short-term interventions. It was noted that PTSD and other responses to trauma persist and fluctuate in severity over time, making access to long-term care essential. Limits placed on the number of counseling sessions were perceived as very restrictive, especially for children, those who were grieving, and those from different cultures. Continuance may be even more important for rescue workers. Many of their problems were not acknowledged until years later. *Flexibility* was suggested as another important characteristic. Regulations that guide crisis counseling programs need to be flexible enough to allow for providing the most appropriate services for a particular event.

Several respondents noted the importance of meeting the needs of culturally diverse groups. The lack of fit between regular services grant requirements and culturally approved ways of helping may prevent some agencies from becoming involved in crisis counseling programs. Credibility is enhanced when consumers believe that providers understand their needs in the context of the culture with which they identify.

Several participants perceived discord between guidelines of the crisis counseling program and either their own orientations or the OKC context. Participants noted that the host system primarily serves the seriously mentally ill. Not all providers were comfortable with brief interventions and the emphasis on outreach as opposed to in-office activities. Many staff members were oriented toward case management, which was not allowed in crisis counseling guidelines. PH was not designed to serve those who needed more intensive treatment. Inherent conflicts between the goals of crisis counseling and those of long-term care were mentioned very frequently.

Many participants expressed concern, often quite strongly, about the use of paraprofessionals in outreach because they would not recognize PTSD and other serious conditions. They believed PH missed opportunities to serve people who may have needed their services the most. The alternative view was also expressed: paraprofessionals may be able to reach segments of the population that professionals ("the white coats") would not have access to, such as the homeless and the seriously mentally ill. According to one peer counselor,

"It doesn't take a rocket scientist to tell that someone is distressed." The use of paraprofessionals for running support groups in the schools was also challenged because these counselors were typically unlicensed and minimally trained. Some perceived as problematic that decisions about continued employment were based on number of client hours, a structure that discouraged referrals.

SUMMARY AND CONCLUSIONS

Participants recommended strongly that other communities not wait until after a disaster to plan a mental health response. Overall, it appeared that OKC was not and is not well prepared. Relying on prior experience is a questionable strategy, as the experience may rest in individuals who are not available in the advent of another major disaster. Programs, personnel, funding, and incentives are essential to assist state mental health authorities to become more prepared and better informed. Recent preparedness grants are now helping to make this possible.

Although it cannot substitute for professional education, training in disaster mental health was perceived as critical for service providers. Training imparts access and entry to systems as well as information and skills. There does not appear to be a training program focused on the longer-term mental health response, leaving communities to depend on non-standardized and unevaluated training programs provided by individual experts. A training program that provides credentialed, comprehensive, state-of-the-art and practical information and skills with regard to immediate, intermediate, and longer-term care would be an important addition to the field.

Although the emergence of insider-outsider dynamics was expected, we were surprised by the frequency with which the topic emerged in the interviews and the intensity of affect associated with it. Care is needed to avoid undermining the natural, appropriate, and empowering need for local control, yet it is unfortunate to deny communities access to information that could be helpful. Mechanisms for credentialing, managing, and coordinating national expertise would help communities find credible, knowledgeable, and respectful consultants. Outsiders who seek to do disaster work or consultation must foster pre-existing relationships with local professionals, mental health authorities, and/or national entities that provide entrée and credibility.

The response of local, state, and national organizations to the OKC bombing was swift and enduring. Providers' dedication and commitment to alleviating the pain of the victims shone through all their comments, even those describing conflicts regarding how best to accomplish shared goals. Further

evaluation of the transition from the emergency period of disaster relief to the period of intermediate and long-term care is needed. Collaboration between the Red Cross, FEMA, and CMHS at the national level could facilitate transitions at the local level.

Project Heartland appears to have done many things well. The structure of using subcontractors to reach diverse segments of the population was novel at the time and largely successful. The subcontractors evaluated Project Heartland as coherent and supportive, which are essential characteristics in our framework. Private practitioners, however, were not well integrated into the long-term response. Relationships between the public and private sectors should be strengthened. CMHS should discuss issues regarding appropriate referrals, fees, and record-keeping with representatives of professional organizations. Professionals' concern about paraprofessionals may reflect some confusion between *outreach* and *triage*; these concepts need programmatic review. Programs need guidance regarding when and where these activities take place.

The stressfulness of providing services after a disaster of this magnitude was profound. A high level of affect was still observable seven years after the event. Systems of care need to be built into program structures, as all of the workers reported that most of their stress was self-imposed. A unilateral rule that creates a maximum term of service for all workers could interfere with program functioning and continuity. However, careful monitoring of provider stress levels is critical. Individual therapy should be made available to both line-workers and management in a process separate from case supervision. Program plans should be required to state explicitly how they will monitor and reduce provider stress. Danieli (2002) emphasized the importance of senior level support for providers, noting that it must be clear that no stigma follows from seeking psychological support. In accord with our observations, she also described trauma's capacity to create ruptures within entire organizations and encouraged "ongoing dynamic dialogues among all layers of involvement" (p. 388).

Findings on serving the consumer are complex and not easy to summarize. Services were evaluated as *accessible*, *acceptable*, *proactive*, and *confidential* but were not always perceived as having *credibility* and *continuance*. The criticisms of PH were, in general, criticisms of the FEMA crisis counseling model. It was not always clear how to conceptualize crisis counseling because the bombing had engendered unthinkable trauma. Many participants believed that consumers' problems were too severe to be treated by unlicensed mental health workers. FEMA and CMHS may need to review the adequacy of relying solely on a crisis counseling model. A more flexible structure, providing

crisis counseling for most but true clinical care for a minority, may be required following major disasters.

The lack of assessment of community-level needs and status makes it impossible to say which side of this debate over treatment needs was accurate. It is quite possible that psychologists and psychiatrists in OKC overestimated the level of need for professional treatment in the community. Valid need assessments could resolve many of the controversies regarding the relative need for counseling versus professional treatment in the community.

Similarly, the lack of empirical evaluation data fueled debate over the quality of the work that was done. There are no data that can establish whether or not the services offered matched consumers' needs or helped them. Beliefs in the efficacy of crisis counseling approaches appeared to follow from perceivers' ideology rather than evidence. CMHS must continue to move in a direction that supports the inclusion of evaluation in program plans.

The limitations of our study should be acknowledged. We elicited only the perspectives of providers, and it will be critical for the voice of consumers to be heard before definitive recommendations can be made. Perspectives were embedded in one community's experience and may not generalize. Likewise, it would be premature to draw conclusions regarding the utility of our conceptual framework. Nonetheless, these findings do provide preliminary support for several of the framework's implications that: (a) host system preparedness facilitates postdisaster response; (b) the fit between providers' orientation and the system's orientation influences judgments regarding system coherence and service effectiveness; and (c) credibility, acceptability, accessibility, proactivity, continuance, and confidentiality compose a minimal set of criteria for postdisaster service delivery.

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